SERVICE RECORDS MANUAL FOR THE FOLLOWING PROVIDERS OF MH/DD/SA SERVICES:

Area Programs/LMEs;
Contract Agencies of Area Programs/LMEs;
Direct Enrolled Residential Treatment; and
CAP-MR/DD

Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Resource/Regulatory Management Section
Regulatory Team

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Table of Contents

Table of Contents

Table of Contents

CHAPTER I: GENERAL INFORMATION

SCOPE

All area programs/LMEs, contract agencies of area programs/LMEs, CAP-MR/DD providers, and direct enrolled residential providers shall follow the documentation requirements contained in this manual. This manual meets Medicaid regulations and has been approved by the Division of Medical Assistance.

REQUIRED ELEMENTS

All providers of MH/DD/SA services in North Carolina as identified in the Scope may develop forms which reflect the require elements as specified in this manual or chose to utilize DMH/DD/SAS sample forms. (See Appendix D)

Note: For CAP-MR/DD consumers, the plan of care and cost summary located in the CAP-MR/DD manual shall continue to be used.

CONSUMER RECORDS TYPES

A consumer record is required to demonstrate evidence of a documented account of all service provisions to a consumer including pertinent facts, findings, and observations about a consumer's course of treatment/habilitation and treatment/habilitation history. The consumer's record chronologically documents the care of the consumer and is an essential element in contributing to a high standard of care.

A consumer record may be paper-based or computer-based. A computer-based record is defined as an electronic consumer record that resides in a system specifically designed to support users by providing accessibility to complete and accurate data, alerts, reminders, clinical support systems, links to medical knowledge, and other aids. A record is not considered computer-based if it is only electronically stored in a computer as a word processing file and not as a part of an electronic database system.

If electronic signatures are used, the requirements specified in Chapter VIII- General Consumer Records Requirements shall be met.

REVISED REPORTING REQUIREMENTS

The following LOE reporting requirements have been eliminated or revised:

1. The Disability Detail Record is no longer required. The record types label in the Client Data Warehouse (CDW) technical reporting requirements as record types (14, 34, and 84) are record types affected by this change. If these record types continue to be reported, the current processing rules shall remain in effect (The Division may require the submission of CAFAS scores on a random sample of consumer's on an annual basis.)
2. In the Demographics Record, the Commitment Status and the Court Order Type is an optional field. The record types labeled 11,31 and 81 in the CDW technical reporting requirements are the record types affected by this change. If these record types continue to be reported, the current validation processing for the range of values specified in the CDW Data Dictionary shall remain in effect.

Note: The latest version of the Technical Specifications document (November 2002, Version 1.5), is posted on the Division's web site (www.dhhs.state.nc.us/mhddsas). A copy may also be obtained by contacting the Communications and Training Section at (919) 733-7011.

CHAPTER II: PROVIDER QUALIFICATIONS

In order to provide services to persons with mental health, developmental disability or substance abuse issues, the provider shall demonstrate knowledge, skills and abilities required to serve the consumer based on the individualized service plan as evidenced by the provider agency's policy. Each MH /DD/SA service definition identifies the specific qualifications required for delivery of that service.

Note: See Appendix A for provider qualifications.

Note: For CAP-MR/DD providers, staff qualifications as specified in the 2001 CAP-MR/DD Manual shall contiunue to be used until further notice.

CHAPTER III: MEDICAL NECESSITY/AUTHORIZATION

MEDICAL NECESSITY

Delivery of all services shall be based upon a finding of medical necessity and/or an assessment of the consumer's need(s) by a qualified professional. Documentation in the consumer's record shall establish the finding of medical necessity.

Policies and procedures shall be developed for the purpose of establishing medical necessity utilizing at least one of the following methods:

- for substance abuse services, ASAM-*PPC*-2R(American Society of Addiction Medicine-*Patient Placement Criteria*);
- for CAP MR/DD, MR2;
- for developmental disabilities; North Carolina Support Needs Assessment Profile (NC-SNAP);
- children in the NC Infant-Toddler Program, Procedures documented in the North Carolina Infant Toddler Program Manual (Bulletins 16 and 22); and
- medical necessity as established in the DMH/DD/SA Service Definitions

SERVICE ORDERS

All MH/DD/SA services reimbursed with Medicaid monies shall be ordered prior to or on the day the service is provided by the appropriate professional as defined in the Medicaid manual and DMH/DD/SA Service Definitions. All area programs/ LME's and provider agencies shall have standing orders for screenings, evaluations, and case consultations.

Each area program/LME shall have a policy regarding how the order of services shall be documented. For example, the area program/LME may develop a policy which requires all services to be documented on a service order form and signed by the appropriate staff on or prior to the date of service, or the policy may require the appropriate staff sign the service plan which identifies the service to be provided and is signed prior to or on the date the service is provided.

For outpatient specialized therapies, (i.e. occupational therapy, physical therapy, speech therapy, and audiological services) a verbal or a written order by a physician shall be obtained for services prior to the start of the services. The verbal order shall be documented in the record and include the date the order was given, who gave the order, who received the order, and what services were ordered. The verbal order must be countersigned within 30 calendar days of the date of the verbal order. Service orders for outpatient specialized therapies cannot exceed a six-month period that begins on the date of the verbal order or the date the physician signs the written order, whichever occurs first. Service providers must review and renew or revise plans and goals at a minimum of every six months, including obtaining another dated physician signature for the renewed or revised orders.
(For additional information, see the North Carolina Medicaid Special Bulletin Section or Medical Policy No. 8F. The bulletin and Medical Policy Section may be obtained from the Division of Medical Assistance web site at www.dhhs.state.nc.us/dma or by contacting EDS at 919-851-8888.)

AUTHORIZATION

Once the limits for unmanaged outpatient visits has been reached, services paid by Medicaid and/or State monies, prior approval shall be obtained from the area program/LME or the external utilization review entity for authorization to continue the service. Private insurance may have specific requirements for establishing medical necessity and obtaining authorization. When this occurs, the private insurance requirements shall be followed. When an individual has both Medicaid and Medicare, Medicare prior approval/authorization requirements supersede Medicaid requirements except in those cases where the recipient is provided a service that is not covered by Medicare. In that case, Medicaid prior approval/authorization requirements shall be followed along with the required F2 stamp for reimbursement.

The area program/LME is responsible for conducting the initial authorization for child residential services. For residential services-Level I, the area program/LME is responsible for all authorization of services. For Level II (both Family and Program type) and Level III, the area program/LME authorizes the initial 120 days. After the initial 120 days, ValueOptions is responsible for authorizing continued stay. For Level IV child residential services, the area program/LME conducts the initial authorization for 30 days, after which time ValueOptions is responsible for authorizing continued stay.

Note: ValueOptions only authorizes services for child residential services with four or more beds. If there are less than four beds, the area program/LME is responsible for authorizing services.

Authorizations for Psychiatric Residential Treatment Facilities (PRTF) services, discharges from a PRTF to a residential facility, when a child is hospitalized directly from a residential facility and returns to the residential facility, and outpatient treatment services for which Medicaid will reimburse shall be authorized by ValueOptions.

For children enrolled in the North Carolina Infant-Toddler Program, services listed on the Individualized Family Services Plan (IFSP) and the signature of the individual representing the appropriate Infant-Toddler Program coordinative agency (ies) for the service(s), or designee is the authorization for services listed on the IFSP.

For outpatient specialized therapy services, i.e. occupational therapy, physical therapy, speech therapy, and audiological services, up to six unmanaged visits per discipline, per provider type are allowed without prior approval. After six unmanaged visits, prior approval is required from Medical Review of North Carolina (MRNC) for continued treatment. For additional information, see the North Carolina Medicaid Special Bulletin Section or Medical Policy No. 8F. The bulletin and Medical Policy Section may be obtained from the Division of Medical Assistance's web site at www.dhhs.state.nc.us/dma or by contacting EDS at (919) 851-8888.

For services that do not require authorization by an external reviewer as noted above but per service definition requires authorization/utilization management, the LME/area program shall develop a policy which establishes an internal process for the authorization/utilization management of these services.

Note: There shall be documentation in the consumer's record that service authorization/utilization review has occurred.

Note: Area program/LME policies for authorization/utilzation management shall incorporate local approval timelines as established for waiver services.

CHAPTER IV: SCREENING/ASSESSMENT

SCREENINGS

There shall be documentation to demonstrate that an individual who is a consumer or who is not a consumer has been assessed for the purpose of determining the nature of the individual's *p*roblem(s) *a*nd need(s) for services and supports. A screening may be conducted face-to-face or by telephone, by a clinician or paraprofessional who has met the competency requirements within their scope of practice to conduct screenings.

An individual may have up to six screening contacts within the fiscal year before the individual is admitted as a consumer.

ASSESSMENT

1. Each individual who is accepted as a consumer must be assessed to appropriately identify need(s)/problem(s) of the consumer and when appropriate, needs for the family of the consumer. The assessment shall be completed within 24 hours.
2. The elements of the assessment process include, but are not limited to:
   a. reason for admission, which include need(s)/problem(s);
   b. strengths;
   c. preferences;
   d. evaluations, as appropriate, including but not limited to psychological, developmental, functional, social, physical, behavioral, economic, intellectual;
   e. mental status, as appropriate; and
   f. diagnosis (es).
3. Information gathered during the screening process or by other means such as discharge summaries, evaluations, etc. may be used to meet the assessment requirements. If other summaries, evaluations, etc. are used to meet these required elements, the summaries, evaluations, etc., shall be referenced and documentation to demonstrate that the information has been reviewed and is still current and accurate. A copy of the referenced document shall be filed in the consumer's record.
4. There may be instances when all elements in the assessment cannot be fully completed. When this occurs, information that is gathered at a later date shall be recorded on the assessment as an addendum with the entry dated and signed by the individual making the addendum.
5. The assessment shall be reviewed and updated as appropriate.

Note: Medicaid criteria for admission of persons under age 21 to a psychiatric hospital or a psychiatric unit of a general hospital can be located in 10A NCAC 22O .0112.

ENTRY MULTIDISCIPLINARY EVALUATION/ ASSESSMENT REQUIREMENTS FOR INFANTS AND TODDLERS

(CFR 303.322; CFR 303.166)

1. For infants and toddlers with or at risk for developmental disabilities, delays or atypical development, there shall be:
   a. an evaluation/assessment conducted within forty-five (45) calendar days of referral to the Infant-Toddler Program;
   b. an evaluation/assessment based on informed clinical opinion;
   c. procedures developed and implemented to ensure participation by the consumer's family or the legally responsible person;

d. an evaluation/assessment administered in the native language or other mode of communication of the child and family;
e. an evaluation/assessment conducted by persons trained to utilize appropriate methods and procedures;
f. a process that does not use a single procedure as the sole criterion for determining a child's eligibility;
g. an integrated evaluation/assessment process developed which involves at least two persons, each representing a different discipline or profession, with the specific number and types of disciplines based on the particular needs of the child; and
h. procedures developed and implemented to fully inform the child's parents or legally responsible person of the evaluation/assessment results.

2. The evaluation/assessment shall contain:
   a. a statement of the child's present level of development in the areas of physical (including gross and fine motor functioning, vision and hearing), communication, cognitive, social-emotional, and adaptive skills development;
   b. a determination of the child's unique strengths and needs in terms of these areas of development and identification of services appropriate to meet those needs;
   c. current medical and health information provided by a physician, a physician extender, or a nurse who has completed the "Child Health Training Program for Registered Nurses" taught under the Division of Public Health Guidelines. (A physician, physician extender, or nurse is not required as one of the disciplines involved in the evaluation/assessment.); and
   d. if desired by the family, a determination of the resources, priorities and concerns of the family, and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with or at risk for a disability. The family-focused and directed assessment shall be based on information provided through a personal interview and incorporate the family's description of these resources, priorities, and concerns in this area.

Note: Additional information regarding the assessment may be found in the document "North Carolina Infant-Toddler Program Manual " available from the Early Intervention Branch of the Women's and Children's Health Section of the Division of Public Health. They can be contacted at (919) 715-7500.

CHAPTER V: SERVICE PLANS

INDIVIDUALIZED SERVICE PLAN

The individualized service plan shall begin at admission and shall be updated/revised to reflect additional needs or changes in the consumer's condition.

CONTENTS OF INDIVIDUALIZED SERVICE PLAN

The individualized service plan shall be based upon the consumer's assessed need(s)/problem(s), with recognition of the consumer's and family's capabilities, interests, preferences, aspirations, and treatment and personal support needs.

An individualized service plan is a comprehensive plan that includes:

1. service goal(s);
2. specific service modalities/interventions with frequency and duration;
3. responsibilities of each member of the treatment/habilitation team;
4. a target date that reflects the timeframe within which the goal(s); modalities/interventions and frequency/duration and responsibilities of each member of the treatment/habilitation team will be reviewed. A target date shall not exceed 12 months.
5. signature of staff and consumer/legally responsible person

Note: Requirements on how to review and revise the service plan are located in the Review/Revision of the Service Plan section in this chapter.

Note: For CAP-MR/DD consumers, the plan of care and cost summary located in the CAP-MR/DD manual shall continue to be used. Revisions to these documents will be made following the next waiver revision approved by CMS.

The service plan shall include both the staff and consumer/legally responsible person's signature demonstrating the involvement of all parties in the development of the plan and the consumer/legally responsible person's consent/agreement to the plan. If the entity that developed the service plan is unable to obtain the signature of both the staff completing the service plan and the consumer/legally responsible person, there shall be documentation on the signature page or in a service note reflecting the attempts to obtain the signature and documentation stating why the signature could not be obtained. When this occurs, there shall be ongoing attempts to obtain the signature(s) as soon as possible.

When the phrase "consumer/legally responsible person" is used and the consumer is a minor or an incompetent adult, the signing of the service plan shall be signed by the legally responsible person.

Exceptions:

a. Per G.S. 90-21.5 (see Appendix B), if the minor is receiving mental health services as allowed in this provision, the minor's signature on the service plan is sufficient. However, once the legally responsible person becomes involved, the legally responsible person shall also sign the plan.

   For minors receiving outpatient substance abuse services, the plan shall include both the staff and the child or adolescent's signatures demonstrating the involvement of all parties in the development of the plan and the child or adolescent's consent/agreement to the plan. Consistent with North Carolina law (G.S. 90-21.5), the plan may be implemented without

parental consent when services are provided under the direction and supervision of a physician. When services are not provided under the direction and supervision of a physician, the plan shall also require the signature of the parent or guardian of the child or adolescent demonstrating the involvement of the parent or guardian in the development of the plan and the parent's or guardian's consent/agreement to the plan.

b. For an emergency admission to a 24-hour facility, per G.S. 122C-223(a), "in an emergency situation when the legally responsible person does not appear with the minor to apply for admission, a minor who is mentally ill or a substance abuser and in need of treatment may be admitted to a 24-hour facility upon his own application." In this case, the minor's signature on the service plan would be sufficient.
c. For an emergency admission to a 24-hour facility, per G.S. 122C-223(b), "within 24 hours of admission, the facility shall notify the legally responsible person of the admission unless notification is impossible due to an inability to identify, to locate, or to contact him after all reasonable means to establish contact have been attempted." Once contacted, the legally responsible person is required to sign the plan.
d. For an emergency admission to a 24-hour facility, per G.S. 122C-223(c), "If the legally responsible person cannot be located within 72 hours of admission, the responsible professional shall initiate proceedings for juvenile protective services." In this case, the individual designated from juvenile protective services shall sign the plan.

Note*:* For minors receiving substance abuse services as a non-emergency admission to a 24-hour facility, both the legally responsible person and the minor are required to sign the service plan.

Note: For Infants and Toddlers, in addition to the parent, the Child Service Coordinator and representatives from agencies having coordinative responsibilities for the services listed on the FSP, or their designee, also must sign the IFSP and be given a copy of the completed IFSP.

Note: For consumers for whom a crisis plan is needed, the service plan shall also include information necessary to carry out a crisis intervention.

REVIEW/REVISION OF THE SERVICE PLAN

A systematic method of reviewing the quality, appropriateness and comprehensiveness of the service plan and a process for initiating plan revisions based on the results of such reviews shall be established.

At a minimum, the service plan shall be reviewed by the responsible professional based upon the target date assigned to each goal, whenever the consumer's needs change, or when a service provider changes.

Note: For CAP-MR/DD consumerss, a new plan shall be completed annually during the consumer's's birthday month.

The review of the service plan shall reflect:

1. a review of the goals, and the modalities/intervention, frequency and duration;
2. the staff's dated signature and the consumer/legally responsible person's dated signature demonstrating their consent or agreement to the plan or a written statement by the entity who developed the plan stating why the consent could not be obtained. The staff reviewing the service plan as well as the consumer/legally responsible person shall also sign and date their signature

whenever the service plan is reviewed whether or not there are any revisions to the plan. The consumer/legally responsible person's signature indicates agreement with the plan as stated and that the plan should continue as documented.

Note*:* Please see above section regarding Contents of Individualized Service Plan for requirements regarding signatures by the consumer/legally responsible person.

For Medicaid consumers who receive psychosocial rehabilitation services, the service plan shall be reviewed at least every six months.

For outpatient specialized therapies (i.e. occupational therapy, physical therapy, speech therapy, and audiological services), the service plan and goals shall be reviewed, renewed or revised no less often than every six months, which includes obtaining another dated physician signature for the renewed or revised orders. The dated physician's signature every six months on the service plan, meets the requirement that the order for outpatient specialized therapies must be renewed or revised every six months.

SERVICE PLAN FOR INFANTS AND TODDLERS WITH OR AT RISK FOR DEVELOPMENTAL DISABILITIES, DELAYS OR ATYPICAL DEVELOPMENT (INDIVIDUALIZED FAMILY SERVICE PLAN-IFSP)

1. The individualized Family Service Plan (IFSP) shall be developed within 45 days of referral to the Infant-Toddler Program for those children determined to be eligible.
   Note: The IFSP shall begin at admission. An IFSP or an interim IFSP may be developed by ECI staff to meet this requirement.

2. The IFSP shall include:
   a. a statement of the child's present health status and levels of development in the areas of physical (including gross and fine motor functioning, vision and hearing), communication, cognitive, social-emotional, and adaptive developments;
   b. with the concurrence of the family, a description of the resources, priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant and toddler with or at risk for a disability;
   c. outcomes for the child, and, if requested, outcomes for the child's family;
   d. planned habilitation procedures related to the outcomes;
   e. a statement of the specific early intervention services necessary to meet the unique needs of the child and family, including the frequency, intensity and method of delivering the services, the natural environments in which the services will be provided, and a justification of the extent, if any, to which the services will not be provided in an natural environment, the location of the services, the payment arrangements, if any, the persons or agencies responsible for providing the services, the projected initiation dates of the services, and the anticipated duration of those services;
   f. the criteria, procedures, and timelines used to determine the degree to which progress towards achieving outcomes is being made and whether modifications, or revisions of the outcomes or services are necessary;
   g. the name of the Child Service Coordinator from the profession most immediately relevant to the needs of the child or family, and who is otherwise qualified to carry out all applicable responsibilities for coordinating with other agencies and individuals and for the development and implementation of the IFSP;

h. a description of medical and other services needed by the child, but which are not required under Part C of the Individuals with Disabilities Education Act, and the strategies to be pursued to secure those services through public or private resources; and
i. the plans for transition into services which are the responsibility of the NC Department of Public Instruction to the extent that these services are appropriate or into other appropriate available services, when the child is not eligible for school services.

3. The initial development process for the IFSP shall include participation by:
   a. the parent(s) of the child;
   b. other family members, as requested by the parent, if feasible;
   c. an advocate or person outside of the family, if the parent requests participation;
   d. the provider(s) of the early intervention services;
   e. the Child Service Coordinator designated for the family, if different from the provider of the early intervention services;
   f. the provider of the evaluation/assessment service, if different from the provider of the early intervention services, and
   g. the surrogate parent, if one was required.
4. Early intervention services for a child and family may commence before the completion of the evaluation/assessment and development of the initial IFSP, if the following conditions are met:
   a. parent consent is obtained;
   b. an interim IFSP is developed that includes the name of the service coordinator who will be responsible for implementation of the interim IFSP and coordination with other agencies and persons, the early intervention services that have been determined to be needed immediately by the child and the child's family, outcomes related to those services, and suggested activities that could be carried out by the family: and
   c. the evaluation/assessment and the initial IFSP are completed within forty-five (45) days of referral to the Infant-Toddler Program.

Note: Additional information regarding the IFSP may be found in the document "North Carolina Infant and Toddler Program Manual" available from the Early Intervention Branch of the Women's and children's Health Section of the Division of Public Health. They can be contacted at (919) 715-7500.

REVIEW OF INDIVIDUALIZED SERVICE PLANS FOR INFANTS AND TODDLERS WITH OR AT RISK FOR DEVELOPMENTAL DISABILITIES, DELAY OR ATYPICAL DEVELOPMENT (INDIVIDUALIZED FAMILY SERVICE PLAN-IFSP)

1. The IFSP shall be reviewed on at least a semi-annual basis or more frequently upon the family's request and carried out by a meeting or by another means that is acceptable to the parents and other participants.
2. The purpose of the semi-annual review is to determine:
   a. the degree to which progress toward achieving the outcomes is being made; and
   b. whether modifications or revisions of the outcomes or services are necessary
3. An annual meeting shall be held to evaluate the IFSP and, as appropriate, revise its provisions.
4. The IFSP semi-annual review and the annual meeting shall include participation by:
   a. the parent(s) of the child;
   b. other family members, as requested by the parent, if feasible;
   c. an advocate or person outside of the family, if the parent requests participation;
   d. the provider(s) of the early intervention services;

e. the Child Service Coordinator designated for the family, if different from the provider of the early intervention services;
f. the surrogate parent, if one was required, and
g. the provider of the evaluation/assessment service, if different from the provider of the early intervention services.

5. The semi-annual or other periodic review shall include participation of persons described in (a)-(g). If conditions warrant, provisions must be made for participation of the other participants identified above. If one of the above-required participants cannot attend a meeting, arrangements shall be made for the person's involvement through other means.

CHAPTER VI: SERVICE NOTE/GRID

CONTENTS OF A SERVICE NOTE

Service notes shall include, but not be limited to, the following:

1. full date the service provided (month/day/year);
2. duration of service for periodic and day/night services;
3. purpose of the contact as it relates to a goal in the service plan;
4. description of the intervention/activity;
5. assessment of consumer's progress toward goals;
6. for professionals, signature and credentials, degree, or licensure of the clinician who provided the service; and
7. for paraprofessionals, signature and position of the individual who provided the service

Case management service notes (which includes CAP-MR/DD case management) shall include the following:

1. date service provided;
2. type of activity (i.e. assessing, arranging, informing, assisting, monitoring, etc.) which relates to a goal in the service plan/plan of care or activities identified on the Case Management/Service Monitoring Plan on CAP-MR/DD plans of care;
3. location where case management services provided (required only for CAP-MR/DD consumers);
4. brief description of the activity and outcome;
5. total time (duration); and
6. signature and credentials, degree or licensure of the case manager

Note: Case management services may be documented on a case management activity log. The log shall include the consumer's name, record number and elements noted above. Initials may suffice for the signature, if each page of the case management activity log includes the signature and credentials, degree or licensure of the case manager with corresponding initials of the case manager. See Appendix D for a sample form.

FREQUENCY OF A SERVICE NOTE

Periodic

1. When a periodic service is provided, a service note that reflects the elements noted above shall be documented at least daily per service by the individual who provided the service.
2. If a case management activity log is used, incidents or significant events in a consumer's life which require additional activities or interventions by the case manager, a full service note shall be documented.
3. CAP-MR/DD services for which a service note, as identified above in Contents of a Service Note, is required are as follows: Crisis Stabilization (including information as indicated in the individual's intervention plan); Family Training; and Therapeutic Case Consultation.

Day/Night

The frequency of day/night services shall be documented as noted below. In addition to the elements noted above in Contents of A Service Note, the date(s) of attendance shall also be documented.

1. Substance Abuse Intensive Outpatient Program-daily
2. Day Treatment Programs and Partial Hospitalization-weekly
3. Psychosocial Rehabilitation-monthly

4. ADVP, Supportive Employment-Group, Community Rehabilitation Program (Sheltered Workshop), Center-Based Developmental Day Services, Day Activity-quarterly.

Note: If the duration of service is less than the above frequency, a service note shall be documented for that period of time. If Medicare is billed for partial hospitalization, Medicare documentation requirements shall be followed.

24-Hour

The following 24-hour services shall be documented as follows:

1. Medical Programs, including Inpatient, Social Setting Detoxification for Substance Abuse- per shift;
2. Facility Based Crisis Services, Residential Treatment-Program Type(Level II), Residential Treatment-High (Level III),Residential Treatment-Secure (Level IV), PRTF- per shift;
3. Residential Treatment (Level I); Residential Treatment-Family Type (Level II)-daily;
4. Group Living, Family Living, Supervised Living-monthly or duration of stay if less than a month;
5. Residential Treatment/Rehabilitation For Individuals With Substance Abuse Disorders-per shift; and
6. Residential Recovery Programs For Individuals With Substance Abuse Disorders And Their Children-per shift

GRID

Contents of a Grid

A grid is a form that is designed to identify the goal(s) that is being addressed and with a key developed specifies the intervention/activity provided and a separate key developed which reflects the assessment of consumer's progress toward goal(s) during that episode of care. A grid shall include:

a. the full date the service was provided (month/day/year);
b. the goals that are being addressed;
c. a number or letter as specified in the key which reflects the intervention/activity;
d. a number or letter as specified in the key which reflects the assessment of the consumer's progress toward goals; and
e. initials of the individual providing the service. The initials shall correspond to a signature on the signature log section of the grid.

The grid shall provide space where additional information may be documented as needed.

A grid, as described above, may only be used for the following services:

a. Day Habilitation;
b. Supported Living;
c. Supported Employment (CAP-MR/DD);
d. Residential Treatment (Level I); and
e. Residential Treatment-Family Type (Level II)

A grid shall be completed daily to reflect services provided.

EXCEPTIONS TO THE ABOVE DOCUMENTATION REQUIREMENTS

For the following services, date of service, duration of service, task performed, signature (initials if full signature included on the page) are required to be documented daily to reflect the service provided:

1. Personal Assistance;

2. MR Personal Care (unless provided by a home care agency that is following their home care licensure rules);
3. In-Home Aide (unless provided by a home care agency that is following their home care licensure rules);
4. Interpreter Services;
5. Adult Day Health Care Services (for references to documentation requirements, see the Division of Aging web site at www.dhhs.state.nc.us/aging for North Carolina Adult Day Care and Day Health State Standards for Certification-10A NCAC 6S or contact them at 919-733-3983).
6. CAP-MR/DD Respite (Hourly, Community, Non-institutional, Nursing*);*
   Note: Institutional respite shall follow the State Mental Retardation Centers documentation requirements.
7. Non CAP-MR/DD Respite-The frequency of documentation for non CAP-MR/DD respite, is as follows:
   a. Hourly-per date of service; and
   b. Community-per duration of the event but not less than weekly

   Note: For additional respite documentation requirements, see Chapter X and Chapter XI in this manual.

Incidents or significant events in a consumer's life, which require additional activities or interventions, shall be documented.

Note: See Chapter IX for documentation requirements for Tangible Supports Services [Environmental accessibility Adaptations, Transportation, Waiver Equipment and Supplies, Personal Emergency Response System (PERS), Vehicle Adaptations, and Augmentative Communications Devices]

ADDITIONAL REQUIREMENTS

1. The completion of a service note or grid to reflect services provided shall be documented within 24 working hours. For reimbursement purposes, documentation shall be properly documented within sixty (60) calendar days from the date the service was provided to ensure the note or grid is properly documented. The area program/LME policy may be more restrictive than the allowed sixty (60) days.
2. If a service note or grid is documented after the required 24 working hours, it shall be considered a "late entry". The entry shall be noted as a "late entry" and at a minimum the date the documentation was made and the date for which the documentation should have been documented. For example, "Late entry made on 4/15/03 for 4/12/03."
3. In all cases, service notes shall be made more frequently than the above requirements when necessary to indicate significant changes in the consumer's status, needs or changes in the service plan.

CHAPTER VII: OTHER SOURCES OF DOCUMENTATION REQUIREMENTS

TREATMENT ALTERNATIVES TO STREET CRIME

(TASC)-The standard operating procedures specified in the June 30, 2000, State of North Carolina Standard Operating Procedures manual shall be followed.

SUBSTANCE ABUSE SERVICES RECORD FOR CHILD AND ADOLESCENT SELECTIVE AND INDICATED PREVENTION SERVICES

The Substance Abuse Prevention Services Record for Child and Adolescent Selective and Indicated Prevention Services record shall be required for all children and adolescents receiving substance abuse selective and indicated prevention services. The requirements of a Substance Abuse Services Record for Child and Adolescent Selective and Indicated Prevention Services are found in Appendix C. Included in the Appendix is the ASAM Adolescent Criteria for Level 0.5: Early Intervention.

CRITERION #5 SERVICES

(N.C. Medicaid Criteria for Continued Acute Stay in an Inpatient Psychiatric Facility)
Criterion #5 services shall only be provided if identified needed services within the community are not available for a minor/adolescent consumer at the discharge date and both the hospital and area program/LME are actively working on implementing the discharge plan. This service requires prior approval. Case management activities may be billed. If case management is billed, there shall be an open record on the minor/adolescent and meet the case management documentation requirements as specified in this manual.

CPT DOCUMENTATION

For CPT documentation requirements, the document "Guide To CPT Conversion for Individual and Group Outpatient Treatment Services" (7/01) shall be followed. This document can be found on the Division's web site www.dhhs.state.nc.us/mhddsas or ordered by contacting the Division's Communication and Training Section at (919) 733-7011.

CAP-MR-MR/MI SERVICE PLAN

The CAP-MR-MR/MI Service Plan shall be completed in accordance with the Development Disability Service Planning Guideline, which is included in the CAP-MR/DD manual. A copy of the CAP-MR/DD manual is available on the Division's web site, www.dhhs.state.nc.us/mhddsas or by contacting the Communications and Training Section at (919)733-7011.

CHAPTER VIII: GENERAL CONSUMER RECORDS REQUIREMENTS

DOCUMENTING IN SERVICE RECORDS

1. All service record entries including assessments/evaluations shall include the date (month/day/year) the service was rendered.
2. All service record entries shall be legible and made in permanent black ink, typewritten or computer generated.
3. Each page in a service record that originated within the area program/LME or provider agency shall include the consumer's name and consumer's record number (when number assigned).

Note: For electronic signature requirements, see the Signatures and Countersignatures Section found in this Chapter.

INACTIVE STATUS

If there has not been face-to-face contact with a consumer within the past twelve months, the consumer shall be placed on inactive status. The Division shall be notified electronically of the consumer being placed on inactive status as specified in the Client Data Warehouse (CDW) Technical Reporting Specifications document.

ABBREVIATIONS

Agencies shall develop a policy and procedure regarding the development and maintenance of an abbreviation list.

CONSUMER CONSENT FOR TREATMENT OR RESEARCH

1. A minor may seek and receive periodic service from a physician without parental consent in accordance with G. S. 90-21.5. (See Appendix B)
2. A consent for treatment shall be signed by the consumer and/ or legally responsible person.
3. A written consent that grants permission to seek emergency medical care from a hospital or physician shall be obtained from the consumer or legally responsible person.
4. For research purposes, a written consent signed by the consumer or legally responsible person shall be obtained to authorize the consumer's participation as a subject in a research project. The consent shall reflect that the consumer and legally responsibility person has been informed of any potential dangers that may exist; conditions of participation are understood; and the consumer has been informed of the right to terminate participation without prejudicing the treatment that is being received.

SPECIAL PRECAUTIONS

1. Known allergies and adverse reactions shall be clearly documented in the consumer's record.
2. A lack of known allergies and sensitivities to pharmaceuticals and other substances shall also be prominently noted in the consumer's record.

CORRECTIONS IN THE CONSUMER RECORD

1. Agencies who utilize an electronic consumer record shall develop procedures that staff is required to follow whenever corrections are necessary in the consumer's record. These procedures shall include the corrections were made by the individual who recorded the entry, the correction shall be electronically signed and dated, and the text shall not be deleted.

2. Whenever corrections are necessary in the consumer's paper record, the following procedures shall be followed:
    a. corrections shall be made by the individual who recorded the entry;
    b. one single thin line shall be drawn through the error or inaccurate entry, making certain the original entry is still legible;
    c. record the corrected entry legibly above or near the original entry;
    d. record the date of the correction and initials of the recorder. An explanation as to the type of documentation error shall be included whenever the reason for the correction is unclear (e.g. "wrong consumer record", "transcription error");
    e. whenever omitted words cannot be inserted in the appropriate place above the record entry, the information should be made after the last entry in the record. Never "squeeze" additional information into the area where the entry should have been recorded.
3. Correcting fluid or tape shall not be used for correction of errors.

INCIDENT DOCUMENTATION

Service Record Documentation

1. Each service provider shall develop and implement a policy regarding the documentation of incidents. Incidents include but are not limited to: death of a consumer; injury to or caused by a consumer; property damage caused by a consumer; alleged abuse, neglect, or exploitation of a consumer; alleged criminal act by a consumer; alleged criminal act by others, having an impact on the consumer; leaving a designated site without supervision when it has been determined that the consumer needs ongoing supervision; violation of the rights of a consumer; accidental injury; adverse reaction to a medication; medication errors; emergency or unauthorized restraint or seclusion; violation of confidentiality of the consumer; suicidal threats and/or attempts.

Note: For consumers that receive CAP-MR/DD funding, the provider shall verbally report all incidents to the Lead Agency within 24 hours or less followed in writing within 72 hours.

Note: The policy shall comply with the Death Reporting rules as specified in 10A NCAC 26C .0300 and Client Rights rules as specified in Client Rights in Community Mental Health, Developmental Disabilities and Substance Abuse Service (APSM 95-2). Copies are available on the Division's web site, **www.dhhs.state.nc.us/mhddsas** or by contacting the Communications and Training Section at (919) 733-7011.

2. The policy shall include the requirement that incidents and other unusual circumstances shall be recorded in the service record including but not limited to:
    a. a description of the event;
    b. actions taken on behalf of the consumer; and
    c. the consumer's condition following the event.

Opinions, conclusions or personnel actions relative to an event shall not be included in the consumer's record.

Administrative Requirements

An administrative system shall be developed for maintaining information on special incidents. When an incident report is completed which includes the administrative review of the incident, (e.g. cause of incident, suggestions to prevent future occurrence or similar incidents, etc.) the report shall not be referenced or filed in the service record but filed in administrative files.

FOLLOW-UP DOCUMENTATION

Follow-up documentation shall reflect attempts to ascertain why a consumer is not attending a service in accordance with the established schedule.

SIGNATURES AND COUNTERSIGNATURES

1. All entries in the service record shall be signed. For professionals, the staff member who provided the service and recorded the event shall sign their name with credentials, degree, or licensure. For paraprofessionals, the individual who provided the service and recorded the event shall sign their name and position.
2. Whenever a staff member is no longer available (extended leave, death, termination from position) to sign a record entry, a notation reflecting this shall be documented in the record with the staff member's supervisor's signature who is signing on behalf of the staff member.
3. Countersignature of entries in the service record shall be required based upon each area facility/LME's policy;
4. A rubber stamp shall be used only for medical reasons and ADA accommodations. If the individual is unable to use the stamp for medical/physical reasons, the individual shall designate an individual authorized to use the stamp. This designation shall be in writing.
5. If an electronic signature is used, the following standards shall be followed:
    - when an electronic signature is used, the provider shall be given an opportunity to review the entry for completeness and accuracy prior to electronically signing the entry;
    - once an entry has been signed electronically, the computer system shall prevent the entry from being deleted or altered;
    - if errors are later found in the entry or if information must be added, this shall be done by means of an addendum to the original entry. The addendum shall also be dated and signed electronically;
    - passwords or other personal identifiers shall be controlled to assure that only the authorized individual can apply a specific electronic signature;
    - any provider authorized to use electronic signatures shall be required to sign a statement that states he is the only one who has access to and will use this specific signature code;
    - an electronic signature shall be under the sole control of the person using it. A provider shall not delegate their electronic signature authorization to another person;
    - policies and procedures shall be adopted to safeguard against unauthorized use of electronic signatures. The policy shall also address sanctions for improper or unauthorized use of the electronic signatures.
    - The governing body shall authorize the use of the electronic signature

Note*:* The above electronic signature standards are subject to revision based upon State law and/or HIPAA requirements.

DOCUMENTATION OF SUSPECTED/OBSERVED CONSUMER ABUSE/NEGLECT

1. Whenever consumer abuse/neglect is observed or suspected, facts relative to the abuse/neglect or suspected abuse/neglect shall be documented in the service record including reports made by the individual consumer and actions taken by staff.
2. Opinions relative to the abuse/neglect or alleged abuse/neglect shall not be documented in incident reports or in the consumer's record.
3. Per G.S. 7B-301, any person or institution has the duty to report abuse, neglect, dependency, or death due to maltreatment of any juvenile to the Director of the Department of Social Services in the county where the juvenile resides or is found.
4. Per G.S. 108A-102, any person having reasonable cause to believe that a disabled adult is in need of protective services shall report such information to the Director of the county department of Social Services in the county in which the person resides or is present.

RECORDS RETENTION AND DISPOSITION

Area programs/LME's and providers of services as specified in this manual shall comply with the Records Retention and Disposition Schedule for State and Area Facilities, Division publication APSM 10-3. A copy is posted on the Division's web site (www.dhhs.state.nc.us/mhddsas) or a copy may be obtained by contacting the Communications and Training Section at (919) 733-7011.

CHAPTER IX: ADDITIONAL DOCUMENTATION REQUIREMENTS WHEN SPECIFIC SERVICES ARE PROVIDED.

SPECIAL ADMISSION REQUIREMENTS-MEDICAL EXAMINATIONS

1. Developmental Disabilities
   a. Day/Night
      - A child/adolescent with developmental disabilities shall have a health assessment before admission or within thirty (30) days following admission.
      - An adult with developmental disabilities who has a medical history which indicates a need for a physical examination shall have a physical examination within twelve (12) months prior to admission, unless there is some unusual medical condition for which more frequent examination is customary practice.
   b. 24-Hour Facility, except respite
      - within 30 days prior to admission, the consumer shall have a medical examination
   c. The physical examination/health assessment shall:
      - assure that the consumer is able to participate in the program;
      - note the presence of any communicable diseases or a communicable condition that presents a significant risk for transmission within the program, except as provided in *G.S.* 130A-144 (Public Health Statutes: "Investigation and Control Measures*")*;
      - include the physician's directions regarding management of the consumer's medical condition, if the consumer has specific medical problems; and
      - for children/adolescent, assure compliance with the immunization requirements in *G. S.* 130A-152 (Public Health Statutes: "Immunization Require*d")*.
2. Mental Health and Substance Abuse
   a. 24-Hour Mental Health Treatment Facility (G.S. 122C-211d)
      - Within thirty (30) days before or after admission, if it is expected that the consumer will remain in treatment for more than thirty (30) days, the consumer shall have a medical examination, unless the consumer can produce a current, valid physical examination report that was completed within twelve (12) months prior to the current admission signed by a physician.
   b. Residential Treatment/Rehabilitation Facility For Individuals With Substance Abuse Disorders
      - Within thirty (30) days before admission or seven (7) days after admission, the consumer shall have a medical examination.
   c. 24-Hour Medical Treatment Facility (G.S. 122C-211c)
      - If medical care is an integral component of the treatment, a medical examination shall be conducted within 24-hours of a voluntary admission.
      - The requirement includes non-hospital detoxification

DISCHARGE PLANS

Discharge Plan for All Disabilities in 24-Hour Services

Prior to discharge, *G.S. 122C-61* requires:

1. an individualized written discharge plan which contains recommendations for further services designed to enable the consumer to live as normally as possible; and
2. a copy of the plan shall be furnished to the consumer or to his legally responsible person and with the consent of the consumer, to the consumer's next of kin. However, a discharge plan may not be

required when it is not feasible because of an unanticipated discontinuation of a consumer's treatment.

Discharge Plan for Consumers Receiving Substance Abuse Services

Per Division publication *A*PSM 30-*1*, Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services, before discharging a consumer receiving substance abuse services, the facility shall complete a discharge plan and refer the consumer to the level of treatment or rehabilitation in accordance with the consumer needs.

MEDICATION-

(See 10A NCAC *27G .0209* in Division publication APSM 30-*1*, Rules for MH/DD/SA Facilities and Services)

1. Medications shall be self-administered by consumers only when authorized in writing by the consumer's physician.
2. A Medication Administration Record (MAR) of all drugs administered to each consumer shall be kept current. The MAR shall include:
   a. consumer's name;
   b. name, strength, and quantity of the drug;
   c. instructions for administering the drug;
   d. date and time the drug is administered; and
   e. name or initials of person administering the drug. If initials are used, the initials with the person's name shall be documented either on the MAR or a specified place in the record.
3. Outpatient Opioid Treatment requires documentation of review with the consumer regarding withdrawal from Methadone or other medications approved for use in narcotic addiction treatment at the initiation *of* treatment and annually thereafter. Documentation shall also include Methadone or other medications approved for use in narcotic addiction treatment given as take home dosages.
4. If the consumer receives psychotropic drugs, a pharmacist or physician shall review the consumer's drug regimen at least every six months. The findings of the review shall be recorded in the consumer's record along with corrective action, if applicable.
5. Whenever medication is prescribed by the area program/LME or provider's physician, there shall be documentation by the physician or designee to demonstrate that either oral or written medication education was provided to either the consumer or legally responsible person, if the ability of the consumer to understand is questionable. Documentation in the consumer's record shall include if the medication education was declined.
6. Drug administration error and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record.
7. A consumer's refusal of a drug shall be documented in the consumer's record.

OUTPATIENT SPECIALIZED THERAPY SERVICES

1. Speech therapy, PT and OT services require an ICD-9-CM diagnosis pertinent to the type of therapy provided.
2. A service order by a physician is required prior to the initiation of treatment. Treatment can proceed on the basis of a verbal order by the physician as long as the verbal order is documented in the consumer's record and the physician countersigns the order within 30 calendar days of the date of the verbal order.

3. The physician's dated signature on the service plan may serve as the order for services.
4. Documentation of the verbal order shall include the date the order was given, who gave the order, who received the order, and the services ordered.
5. A service order for specialized therapy cannot exceed six months based on the date of the verbal order or the date the physician signed the order, whichever comes first.
6. Each provider (i.e. biller) shall maintain the following documentation for each individual:
    a. the patient's name and Medicaid identification number;
    b. a copy of the service plan with clearly defined goals, frequency, and length of visits for the services;
    c. a copy of the area mental health center/LME's standing order for assessment services;
    d. a copy of the physician's signed order for treatment;
    e. progress notes with dates of service and a description of services which includes the intervention and outcome/consumer response as they relate to goals in the service plan;
    f. the duration of service (i.e. length of assessment and/or treatment session in minutes);
    g. the signature of the person providing each service;
    h. a copy of each test performed or a summary listing all test results, and the written evaluation report; and
    i. a copy of the completed prior approved form with the prior approval number.

THERAPEUTIC LEAVE

1. Documentation shall reflect the number of days of service and include verification of therapeutic leave days.
2. Documentation related to the therapeutic leave shall include:
    a. the length of time for the leave;
    b. justification for each therapeutic leave episode; and
    c. a statement regarding the consumer's condition prior to and after return from the leave
3. ICF-MR Facilities shall comply with Medicaid requirements pertaining to therapeutic leave.
4. For Medicaid eligible consumers in a Level II, Level III, Level IV Residential Facility, PRTF for which the N.C. Medicaid Program is paying reimbursement for these services, the necessity of therapeutic leave and the expectations involved in such leave shall be documented in the consumer's treatment/habilitation plan and the therapeutic justification for each instance of such leave entered in to the consumer's record maintained at the Residential/PRTF Facility's site. Facilities shall keep a cumulative record of therapeutic leave days taken by each consumer for reference and audit purposes.

PUBLIC EDUCATION

Public education that is offered to consumers shall maintain school records separate from the consumer record unless:

1. the teachers are employed by or under the supervision of the area program/LME or provider agency rather than the public school system; or
2. the facility is a contract agency operated by the public schools and the teachers receive training relative to service record documentation procedures and confidentiality. When monitoring is conducted by personnel from the public school system or Department of Public Instruction, access to school records/information is allowed; however, access to consumer records shall be in conformance with the Confidentiality Rules, Division publication APSM 45-1.

Only copies of information from the consumer record, which are pertinent to the Individualized Education Plan (IEP), shall be included in the school record without consent of the consumer or his legally responsible person. When administrative audits are performed on school records, only that information necessary to conduct the audit is to be disclosed to audit personnel.

NON-HOSPITAL MEDICAL DETOXIFICATION SERVICES

Each consumer's pulse rate, blood pressure, and temperature shall be monitored and recorded at least every four hours for the first 24 hours and at least three times daily thereafter.

SOCIAL SETTING DETOXIFICATION SERVICES

Each consumer's pulse rate; blood pressure and temperature shall be monitored and recorded at least four times daily for the first 72 hours after admission.

WORK FIRST/SUBSTANCE ABUSE INITIATIVE

Additional documentation shall include any barriers to services.

OUTPATIENT OPIOID TREATMENT

Additional documentation shall include:

1. program compliance including results of drug screens;
2. medication take-home eligibility;
3. operating hours;
4. initial and subsequent annual discussion with patients of the risks and benefits of withdrawal from methadone or other approved medications;
5. random and observed drug screens; and
6. establishment and maintenance of a Diversion Control Plan.

CHAPTER X: EXEMPTIONS FROM SPECIFIED DOCUMENTATION

REQUIREMENTS

The following services have documentation requirements that differ from requirements noted elsewhere in the manual.

Respite

1. When the consumer is receiving other services:
    a. information regarding special behavioral conditions, nutritional, medical, medications to be administered, or other service needs of the consumer shall be documented and given to the respite provider. There shall be documentation to demonstrate these special needs were given to the provider.
        1) These special instructions shall be followed and no specific service plan is required for respite care.

        Note: For CAP-MR/DD consumers, the plan of care shall reference Respite Services.
        2) Documentation shall include:
            i. The date(s) of service and for hourly respite, duration of the service event;
            ii. Tasks performed including any comments on any behaviors, etc., which are considered relevant to the consumer's continuity of care; special instructions were followed; etc.; and
            iii. Signature (initials if full signature included on the page)
2. Consumer Not Receiving Other Services:
    When a consumer is only receiving respite services, the documentation requirement noted in the Modified Records Section shall be followed.

TANGIBLE SUPPORTS

The following tangible supports may be provided to a consumer with the documentation as noted below. A service note or grid as specified in Chapter 6-Service Notes/Grid of this manual is not required.

Environmental Accessibility Adaptations

1. Assessment/recommendation by an appropriate professional that identifies the person's need(s) with regard to the Environmental Accessibility Adaptation(s) being requested.
2. Copy of the physician's signature certifying medical necessity is included with the request for Environmental Accessibility Adaptations. The physician may sign a statement on the assessment/recommendation certifying that the requested adaptation is medically necessary or may sign a separate document.
3. Outcomes/goals related to training needs associated with the person/family's utilization and/or procurement of the requested adaptation(s) are included in the Plan of Care as appropriate.

Transportation

1. If the trip is being billed by the mile rather than by an established charge, a record shall be maintain that documents the date the service is provided, the specific activity that the person is being transported to/from, and the mileage related to transporting the person. The person providing the transportation shall sign this record.
2. If the trip is being billed with an established charge per trip, the signature of a representative providing the transportation is required.

Waiver Equipment and Supplies

1. Assessment/recommendation shall be completed by an appropriate professional that identifies the individual's need(s) with regard to the Waiver Equipment and Supplies being requested. Diagnostic information must be consistent with the recommended supplies/equipment. The assessment/recommendation must state the amount of an item the person needs. The assessment/recommendation must be updated if the amount of the item the person needs changes.
2. A copy of the physician's signature certifying medical necessity shall be included with the request for Waiver Equipment and Supplies. The physician may sign a statement on the assessment/recommendation certifying that the requested supply/equipment is medically necessary or may sign a separate document.
3. Outcomes/goals related to the person/family's utilization and/or procurement of the requested supplies/equipment must be included in the plan of care. If the equipment/supply is related to outcomes/goals already in the service plan, this should be noted in the request for the equipment/supply. Outcomes must be consistent with the recommendations for the supplies/equipment.

Personal Emergency Response System (PERS)

Maintain a record that documents the date service is started, the dates that it is provided, and the date it is terminated.

Vehicle Adaptations

1. Recommended equipment or modification shall be justified by an assessment from a Physical Therapist/Occupational Therapist specializing in vehicle modifications or a Rehabilitation Engineer or Vehicle Adaptation Specialist and accompanied by a physician's signature certifying medical necessity for the person. These assessments shall contain information regarding the rationale for selected modification, consumer pre-driving assessment-if the CAP-MR/DD consumer will be driving the vehicle, condition of the vehicle to be modified, insurance on the vehicle to be modified, and training plan for the use of the prescribed modification.
2. Documentation regarding each of the requirements specified above, as well as a revised cost summary and service plan signature page must be submitted to the Lead Agency Local Approver in order to obtain prior approval of the requested Vehicle Adaptations.

Augmentative Communications Devices

1. Assessment/ recommendation signed and dated by a NC Licensed Speech-Language Pathologist with the SLP's license number shall be submitted with the request. The assessment/ recommendation is also signed and dated by other appropriate professionals as needed. The recommendation must be less than one year old from the date the request is received in the Lead Agency Local Approval Office. The assessment confirms medical need for the equipment rather than educational need and identifies the person's need(s) with regard to Augmentative Communication equipment being requested. A copy of the physician's statement certifying medical necessity shall be included with the request.
2. The request shall include clear documentation that the equipment is necessary to enable the individual to produce and engage in communication, either spoken, written, or both, in the absence of functional oral language. Information shall be provided that includes the person's hearing status, visual status, physical status, access for the device requested (i.e. use of hand, visual scanning, auditory scanning, etc.), cognitive status, and primary communication method(s).
3. Outcomes for teaching the use of the device to the consumer and his/her care providers that match the assessment results/device(s) requested shall be included.

4. The estimated life of the equipment, as well as the length of time the person is expected to benefit from the equipment, shall be indicated in the request.
5. An invoice from the supplier that shows the date the Augmentative Communication was provided to the person, and the cost including related charges (for example, applicable delivery charges) shall be maintained by the Lead Agency.

Inclusive Day Programs

1. For each consumer, the inclusive day program record shall include a service plan, if applicable, strategies or activities which are the responsibility of the inclusive program provider, and an attendance hour record.
2. Staff who support children in these placements shall document a service plan as noted in the Individualized Service Plan Section and service notes as described in the Service Notes/Grid Section.

Developmental Day Services-Typically Developing Children

Documentation as required by the NC Division of Child Development's Child Care Requirements, Subchapter 3U-Child Day Care Rules shall be followed. The Division of Child Development may be contacted by calling (919)662-4499.

Developmental Day Services-Before/After School

The record shall contain a copy of the IEP or IFSP from the regular day program.

Community Rehabilitation Program (Sheltered Workshop Programs)

The documentation requirements specified in this document do not apply to consumers supported by the Division of Vocational Rehabilitation. For these consumers, documentation requirements specified by the Division of Vocational Rehabilitation shall be followed.

CHAPTER XI: MODIFIED CONSUMER RECORD

LIMITATIONS OF USE FOR MODIFIED CONSUMER RECORDS

1. Modified records shall be used only for:
    a. Respite (if this is the only service being provided); and
    b. Other Services, if approved by the Division
2. When an individual receives services in addition to those listed above, a consumer record shall be opened and the same record number shall be used. Modified consumer record documentation may be filed in the consumer record.

RESPITE SERVICES

The following documentation is required if Respite is the only service received:

1. Identification/face sheet and diagnostic information;
2. Special behavioral conditions, nutritional, medical, medications to be administered, or other service needs of the consumer. These special instructions shall be given to the respite provider and no specific service plan is required for respite care.

   Note: For CAP-MR/DD consumers, the plan of care shall reference Respite Services.
3. Service notes shall include:
    a. The date(s) of the service and for hourly services duration of the service event;
    b. Tasks performed including any comments on any behaviors, etc., which are considered relevant to the consumer's continuity of care; documentation that special instructions were followed, etc.; and
    c. Signature (initials if corresponding full signature included on the page)

CHAPTER XII: SERVICES NOT REQUIRING A SERVICE PLAN

PENDING RECORDS

1. Screenings;
2. Referrals;
3. Drop-In Center Services;
4. Case Consultation; and
5. Assertive Outreach

SCHOOL RECORDS DOCUMENTATION REQUIREMENTS (ADETS AND DES)

Documentation for school records shall include:

1. Information regarding the initial assessment to determine eligibility to attend school;
2. The appropriateness of the referral to a treatment resource, if applicable;
3. For ADETS, a copy of Form No. DMH-508, "DWI Services Certificate of Completion";
4. For DES, a copy of Form No. DMH-4401, "Drug Education School of Completion Form";
5. Documentation of other relevant transactions and student contacts, i.e. referral to another county and/or non-compliance issues and outcomes;
6. Pre-test and post-test scores; and
7. Homework assignments, if any.

A record shall be maintained in the administrative files for each student.

An individual may voluntarily move from student status to consumer status when it has been determined that the individual is in need of active treatment/habilitation and is accepted as a consumer. Once a student becomes a consumer, a consumer record shall be opened.

A determination shall be made whether ADETS or DES record shall be incorporated into the consumer record.

HELP-LINE, CONSULTATION, EDUCATION AND PRIMARY PREVENTION, EMPLOYEE ASSISTANCE PROGRAM (EAP) DOCUMENTATION REQUIREMENTS

Documentation for other service records shall include:

1. Help-Line
    a. Caller's name, address and telephone number, when possible;
    b. Probable age and disability of the individual who is the subject of the call;
    c. Brief description of the type of complaint or problem;
    d. Disposition/recommendation for further care;
    e. Date and time of contact; and
    f. Authentication by persons receiving the call.
2. Consultation, Education and Primary Prevention
    a. Person/agency receiving consultation;
    b. Type of group participating in educational or prevention program;
    c. Approximate number of participants;
    d. Date and duration (time) of the event;
    e. Description of the event; and
    f. Staff member participating in the event.

3. Employee Assistance Program (EAP)
    a. Identifying information of employee;
    b. Name of the company/firm where employee works;
    c. Complaint or presenting problem of employee;
    d. Assessment of problem(s) or need(s);
    e. Disposition (referrals and/or recommendations);
    f. Date of contact; and
    g. Signature and credentials, degree or licensure of the staff member who provided the service.

If an individual receiving EAP services is determined to be in need of treatment/habilitation and is accepted as a consumer, a consumer record shall be opened. A determination shall be made whether the EAP record shall be incorporated into the consumer's record.

CHAPTER XIII: PRIVACY AND SECURITY OF RECORDS

Policies and procedures as required by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA regulations shall be developed.

SAFEGUARDS

Policies/procedures regarding the following shall be developed:

1. Ensures the safeguard of service records against loss, tampering, defacement, or use by unauthorized persons and ensures that service records are readily accessible to authorized users at all times.
2. If confidential information is stored in portable computers, a policy shall be developed which address the protection of such information. Recommended areas that the policy should address are as follows:
    a. The loan and use of portable computers;
    b. Purging confidential data from returned computer prior to assigning the same computer to the next user;
    c. Avoid maintaining confidential information on portable computers. Store confidential information on the facility network so the information can be backed up and maintained more securely. If net work storage is not possible, maintain the information on disk(s) and transport the disks separately from the computer case.
3. If the faxing of confidential information is allowed, policies/procedures to reflect how the information being faxed will be protected;
4. If email is used to communicate confidential information, a policy regarding how the confidential information will be secured and protected shall be developed.

If an electronic medical record is utilized, the following, but not limited to, policies shall be developed:

1. A policy, which defines the classifications of information (data sets) to which different users, may have access.
2. A policy, which specifies only identified users, has access to consumer information. The policy shall identify measures such as passwords, audit trails (a detailed record of who looked at, entered, or changed data, and when), etc. to help ensure only identified users have access to consumer information.

CONFIDENTIALITY

In addition to the HIPAA regulations, confidential information shall also be protected as follows:

1. Information in service records for individuals who receive mental health and developmental disabilities shall be disseminated in accordance with G.S. 122C-51 through G.S. 122C-56 and the Confidentiality Rules codified in 10A NCAC 26B (Division publication APSM 45-1).
2. Information in service records for those individuals who receive substance abuse services shall be disseminated in accordance with 42 C.F.R., Part 2-"Confidentiality of Alcohol and Drug Abuse Patient Records".

3. Information in service records serving infants and toddlers in the I-TP and who are at risk for atypical development, developmental delay or developmental disability shall be released or disclosed in accordance with the federal regulations 34 C.F.R. Part 303.460(Part C-IDEA), 34 CFR Part 300.560-300.576(Part B-IDEA),CFR Part 99(FERPA).
4. Information relative to AIDS or related conditions shall only be disclosed in accordance with the communicable disease laws as specified in *G.S.* 130A-143.
5. Secondary records, which contain information wherein a specific consumer or consumers can be personally identified, shall be protected with the same diligence as the original consumer record.

TRANSPORTING RECORDS

Service records shall only be transported by individuals designated by the agency:

1. When original service records are removed from the facility premises, efforts shall be made to ensure that the records are packaged safely and securely. When service records are transported by motor vehicle, service records shall be secured in a locked compartment (e.g. locked car, locked trunk).
2. Policies and procedures relative to transporting records shall be developed.

CHAPTER XIV: INDICES AND REGISTERS

The following indices and registers shall be permanently maintained manually or electronically:

1. Master Consumer Index
   This index is a file of persons served.
2. Consumer Number Control Register
   This register controls the assignment of consumer record numbers. Any consumer admitted shall retain the same consumer record number on subsequent admission.

APPENDIX A

Professional and Paraprofessional Categories

PROFESSIONAL CATEGORIES AND DEFINITIONS

Within the DMH/DD/SAS system of care, the qualified professional means an individual serving in the following categories:

Independent Practitioner

An independent practitioner is an individual who holds an unrestricted license, certificate, registration, issued by the board regulating the profession in question, in the following disciplines: Ph.D. Psychologist, Psychiatrist, Certified Clinical Social Worker, Clinical Nurse Specialist certified in Psychiatric Mental Health Advanced Practice Nursing, Licensed Clinical Social Worker, Licensed Occupational, Physical and Speech Therapist and who provides and bills MH/DD/SAS services under their own provider number and through employment or contract with an area program or other billing provider.

OR

Independent Practitioner Provisional

An independent practitioner provisional has a limited, provisional and temporary license, certificate, registration or permit in the disciplines listed above issued by the governing board regulating the profession and requires clinical supervision by a qualified independent practitioner and provides and bills MH/DD/SA services under their own provider number and through employment or contract with an area program or other billing provider.

OR

Qualified Professional of MH/DD/SA Services

1. A graduate of a college or university with a Masters degree in a related human service field and has one year of full-time, post-graduate accumulated MH/DD/SA experience with the population served and a substance abuse professional shall have one year of full-time post-graduate accumulated supervised experience in alcoholism and drug abuse counseling;

OR

2. A graduate of a college or university with a baccalaureate degree in a related human service field and has two years of full-time, post-baccalaureate accumulated MH/DD/SA experience with the population served and a substance abuse professional shall have two years of full-time post-graduate accumulated supervised experience in alcoholism and drug abuse counseling;

OR

3. A graduate of a college or university with a baccalaureate degree in a field not related to human services and has four years of full-time, post-baccalaureate accumulated MH/DD/SA experience with the population served and a substance abuse professional shall have four years of full-time post-graduate accumulated supervised experience in alcoholism and drug abuse counseling;

OR

4. A substance abuse professional who has a counseling certification by the North Carolina Substance Abuse Professional Certification Board;

OR

5. A registered nurse who is licensed to practice in North Carolina by the North Carolina Board of Nursing and has four years of full-time accumulated experience in psychiatric mental health nursing.

Associate Professional Category

Associate Professional (AP)

1. A graduate of a college or university with a Masters degree in a related human service field with less than one year of full-time, post-graduate accumulated MH/DD/SA experience with the population served, and a substance abuse professional with less than one year of full-time, post-graduate accumulated supervised experience in alcoholism and drug abuse counseling.

Upon hiring, an individualized supervision plan shall be developed and supervision shall be provided by a qualified professional with the population served until the individual meets one year of experience;

OR

2. A graduate of a college or university with a baccalaureate degree in a related human service field with less than two years of full-time, post-baccalaureate accumulated MH/DD/SA experience with the population served, and a substance abuse professional with less than two years of full-time, post-baccalaureate accumulated supervised experience in alcoholism and drug abuse counseling. Upon hiring, an individualized supervision plan shall be developed and reviewed annually. Supervision shall be provided by a qualified professional with the population served until the individual meets two years of experience;

OR

3. A graduate of a college or university with a baccalaureate degree in a field not related to human services with less than four years of full-time, post- baccalaureate accumulated MH/DD/SA experience with the population served, and a substance abuse professional with less than four years of full-time post-baccalaureate accumulated supervised experience in alcoholism and drug abuse counseling. Upon hiring, an individualized supervision plan shall be developed and reviewed annually. Supervision shall be provided by a qualified professional with the population served until the individual meets that four years of experience;

OR

4. A registered nurse who is licensed to practice in North Carolina by the North Carolina Board of Nursing and has less than four years of full-time accumulated experience in psychiatric mental health nursing.

Paraprofessional Category

Paraprofessional

a. a GED or high school diploma; or
b. no GED or high school diploma, employed prior to November 1, 2001 to provide a MH/DD/SA service; and
c. upon hiring, an individualized supervision plan shall be developed and supervision shall be provided by a qualified professional or associate professional with the population served

Note: The phrase "provides and bills MH/DD/SA services under their own provider number" included in the above categories applies only to those disciplines for which Medicaid has approved for direct enrollment.

APPENDIX B

General Statute for Minor Consent

G.S. 90-21.5-Minor's Consent Sufficient for Certain Medical Health Services

1. Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-222. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-222.
2. Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child.

APPENDIX C

Substance Abuse Services Record For Child and Adolescent Selective and Indicated Prevention Services

SUBSTANCE ABUSE SERVICES RECORD FOR CHILD AND ADOLESCENT SELECTIVE AND INDICATED PREVENTION SERVICES

The **Substance Abuse Prevention Services Record** shall be required for all children and adolescents receiving substance abuse selective and indicated prevention services and shall meet the following minimum requirements:

- **Client Data Warehouse (CDW) Requirements:** Documentation of designated reporting requirements of the Client Data Warehouse (CDW) for substance abuse admission and discharge. Indicated are all of the regulatory and required CDW items with the exception of not requiring "Substance Abuse (Drug of Choice) Details" or "Substance Abuse Treatment (Movement) Details".
- **Documentation of Child or Adolescent Risk Profile:** Documentation of the findings of a child or adolescent risk profile that identifies one or more designated risk factors for substance abuse.
- **Assessment and Plan:** Each child or adolescent shall be assessed with documentation of individual risk factor(s), history of substance use, if any, a description of the child's or adolescent's current substance use patterns, if any, and attitudes towards use. Documentation shall Include other relevant histories and mental status that is sufficient to rule out other conditions suggesting the need for further assessment and/or treatment for a substance abuse or dependence diagnosis and/or a co-occurring psychiatric diagnosis. The plan shall be based on the child's, adolescent's, and/or family's problems, needs, and risk factors, with recognition of the strengths, supports, and protective factors. The plan shall match the Child or Adolescent Risk Profile with an appropriate evidence-based program for selective or indicated substance abuse prevention services that addresses the child's or adolescent's and/or family's knowledge, skills, attitudes, intentions, and/or behaviors. The plan shall include both the staff and the child or adolescent's signatures demonstrating the involvement of all parties in the development of the plan and the child or adolescent's consent/agreement to the plan. Consistent with North Carolina law (G.S. 90-21.5), the plan may be implemented without parental consent when services are provided under the direction and supervision of a physician. When services are not provided under the direction and supervision of a physician, the plan shall also require the signature of the parent or guardian of the child or adolescent demonstrating the involvement of the parent or guardian in the development of the plan and the parent's or guardian's consent/agreement to the plan.
- **ICD-9 Classification of V65.42 Counseling on Substance Use and Abuse**
  Included shall be the ICD-9 Supplementary Classification of Factors Influencing Health Status and Contact with Health Services for persons seeking consultation without complaint or sickness for preventative health advice, education, or instruction through the code of V65.42 Counseling on Substance Use and Abuse.
- **Use of ASAM Placement Criteria:** The ASAM Placement Criteria Adolescent Admission Criteria for Level 0.5: Early Intervention shall be used for all children and adolescents with appropriate documentation of the individual's presentation in each of six dimensional criteria.
- **Consent for Participation:** In all circumstances the child or adolescent shall sign consent for participation in substance abuse selective or indicated prevention services. Consistent with North Carolina law (G.S. 90-21.5), a qualified substance abuse prevention professional may provide these services to a minor without parental consent when practicing under the direction and supervision of a physician licensed in North Carolina.

  In the event that these substance abuse prevention services are not provided under the direction and supervision of a physician, the consent of the parent or legal guardian of the child or adolescent is required in addition to the consent of the child or adolescent.

- **Service Grid:** A service grid shall include a notation following the delivery of each service and shall include the date and duration of the service that was provided, a listing of the individual child or adolescent and/or his or her family members that were in attendance, an identification of the evidence-based program module and service type, session goal, standard activity description, and initials of the staff member providing the service. The initials shall correspond to a signature with credentials identified on the signature log section of the service grid. Also to be documented, as appropriate, shall be a special notation of any child or adolescent significant findings or changes in status that pertain to the provision of services at the current level of care or the need for referral for other services.
- **Individual and Family Outcomes:** Documentation shall include the findings of the standardized pre-tests and post-tests associated with the evidence-based program being implemented, and the individual and/or family outcomes resulting from the program intervention.

USE OF ASAM FOR SELECTIVE AND INDICATED PREVENTION SERVICES

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has adopted the American Society of Addiction Medicine ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R) for use by all area programs and contract agencies. The Adolescent Patient Placement Criteria for Early Intervention Level 0.5 should be used for all children and adolescents being assessed for the Target Population Categories of Selective Prevention and Indicated Prevention in the Integrated Payment and Reporting System (IPRS). The ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition - Revised (pp. 179-208) reads as follows:

ASAM Adolescent Criteria for Level 0.5: Early Intervention

Early Intervention is an organized service that may be delivered in a wide variety of settings. Early intervention services are designed to explore and address the adolescent's problems or risk factors that appear to be related to substance use and to assist the adolescent in recognizing the harmful consequences of substance use.

Setting

Level 0.5 services may be offered in any age-appropriate setting, including clinical offices or permanent facilities, schools, work-sites, community centers, or an adolescent's home.

Staff

Level 0.5 services may be provided by any professional who is knowledgeable about the biopsychosocial dimensions of substance abuse and dependence, knowledgeable about adolescent development, experienced working with and engaging adolescents, able to recognize mental health concerns and substance-related disorders; skilled in alcohol and other drug education, motivational counseling, and brief intervention techniques; and aware of the legal and personal consequences of inappropriate substance use.

Interventions

Interventions offered at Level 0.5 may involve individual, group or family counseling, as well as planned educational experiences focused on helping the adolescent recognize and avoid substance abuse.

Assessment

At Level 0.5, sufficient assessment is performed to screen for, and rule out, substance –related and co-occurring psychiatric disorders. Screening instruments may be used.

Documentation:

Documentation standards of Level 0.5 include progress notes in the adolescent's record that clearly indicate the assessment findings, attendance and significant clinical events, particularly those that require further assessment and referral.

ASAM Level 0.5 Early Intervention ● Adolescent Admission Criteria Diagnostic and Dimensional Criteria

Diagnostic Admission Criteria:

The adolescent who is an appropriate candidate for Level 0.5 services evidences problems and risk factors that appear to be related to substance use but do not meet the diagnostic criteria for Substance-Related

Disorder as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria.

Dimensional Admission Criteria:
The adolescent who is an appropriate candidate for Level 0.5 services meets one of the specifications in Dimensions 4, 5, or 6. Any identifiable problems in Dimensions 1, 2 or 3 are stable or are being addressed through appropriate outpatient medical or mental health services.

Dimension 1:
Intoxication and/or Withdrawal: The adolescent who is an appropriate candidate for Level 0.5 services shows no signs of acute or sub-acute withdrawal, or risk of acute withdrawal.

Dimension 2:
Biomedical Conditions and Complications: In Dimension 2, the adolescent's biomedical conditions or problems, if any, are stable or are being actively addressed through appropriate medical services and will not interfere with therapeutic interventions at this level of care.

Dimension 3:
Emotional, Behavioral or Cognitive Conditions and Complications: In Dimension 3, the adolescent's emotional, behavioral or cognitive conditions or complications, if any, are stable or are being actively addressed through appropriate mental health services and will not interfere with therapeutic interventions at this level of care.

Dimension 4:
Readiness to Change: In Dimension 4, the adolescent expresses willingness to gain an understanding of how his or her current use of alcohol or other drugs may be harmful or impair his or her ability to meet responsibilities and achieve personal goals.

Dimension 5:
Continued Problem Potential: The adolescent's status in Dimension 5 is characterized by (a) or (b):
The adolescent does not understand or accept the need to alter his or her current pattern of use of alcohol of other drugs in order to prevent harm that may be related to such use; or
The adolescent needs to acquire the specific skills needed to change his or her current pattern of use.

Dimension 6:
Living Environment: The adolescent's status in Dimension 6 is characterized by (a) or (b) or (c) or (d):

a. A significant member of the adolescent's social support system has a pattern of substance use that prevents him or her from meeting social, work, school or family obligations; or
b. One of more family members are abusing alcohol of other drugs (or have done so in the past), thereby heightening the adolescent's risk for a substance-related disorder; or
c. A significant member of the adolescent's social support system expresses values concerning alcohol or other drug use that pose a risk to the adolescent of initiation of such use or progression of an established pattern of substance use; or
d. A significant member of the adolescent's social support system condones or encourages use of alcohol or other drugs.

APPENDIX D

Sample Forms

INSTRUCTIONS ON HOW TO USE THE GRID

Purpose: The purpose of the grid is to provide a means to quickly capture the goal(s) addressed, the staff's intervention/activity and the assessment of the consumer progress toward the goals established.

1. **Page __ of __:** Number of sheets that will be needed per 15-day cycle will depend on how many goals the consumer has in the service plan.

2. **Consumer's Name:** Ente*r* consumer's name as recorded in the consumer's medical record.

3. **Record Number:** Ente*r* the consumer's medical record's number.

4. **Month/Year:** Ente*r* the month and year service was received by the consumer

5. **Shift:** When appropriate, enter the shift for which the entries represent.

6. **Specify Service:** *E*nter the specific service for which the form is being used (i.e. Residential Treatment-Level II, Supported Living, etc).

7. **Area Program/LME:** *E*nte*r* the name of the area program/LME.

8. **Service Provider/Agency:** If the service is provided by an agency other than the area program/LME, enter the name of the provider/agency.

9. **Goal(s):** Enter the goal as stated in the consumer's service plan. The goal should be written as documented in the service plan.

10. **Key:** A key(s) utilizing letters shall be developed to reflect interventions/activities. A key(s) utilizing numbers shall be developed to reflect the assessment of the consumer's progress toward the goals. All keys developed shall be identified in a Key Menu.

    On the grid in the Key box, identify in the top part of the box labeled "I", the key to be used to reflect the interventions/activities. On the bottom part labeled "A", the key to be used to reflect the assessment of the consumer's progress toward the goals.

11. **Numbered Boxes 1-15/16-31:** Each numbered box represents a day of the month. Number of boxes used will depend on how many days are in that particular month. Each box is divided into an upper half and a lower half. The top half of the box represents the intervention/activity provided- (noted as an I in top half of the key section) and the lower half (noted as an A) represents the assessment of the consumer/resident's progress toward the goals; Based upon the key identified in the Key box, assign a letter which represents the intervention/activity provided and a number which represents the assessment of consumer's progress toward goals. A number can be placed in front of the key used to signify how many interventions/activity (ies) staff made.

12. **Duration:** Duration shall be recorded if the service is a periodic or day/night service.

13. **Date**: This is the dated signature, i.e. initials. Enter the date the documentation is initialed and signed for services provided to the consumer.

14. **Initials:** The provider shall initial for each day he/she provides a service to the consumer. The initials shall correspond to the section on the back of the form called All Staff Persons Working With This Individual Must Fill Out The Information Below.

15. **Comments:** Each entry shall be dated. This section is for additional information such as to further explain the intervention/activities or assessment of consumer's progress toward goals.

16. **All Staff Persons Working With This Individual Must Fill Out The Information Below:** A staff person working with the consumer shall complete this section which includes the staff person's printed name, full signature, and initials.

North Carolina Division of Mental Health/ Developmental Disabilities/ Substance Abuse Services

Consumer Name _____ **Record Number** _____ **Month/Year** _____ **Shift** _____

Specify Service: _____ **Area Program/LME** _____ **Service Provider/ Agency:** _____

Goals	*Key*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	(I)																
	(A)																
	(I)																
	(A)																
	(I)																
	(A)																
Duration (when required):																	
Date:																	
Initials:																	

GRID

North Carolina Division of Mental Health/ Developmental Disabilities/ Substance Abuse Services

Consumer Name _____ **Record Number** _____ **Month/Year** _____ **Shift** _____

Specify Service: _____ **Area Program/LME** _____ **Service Provider/ Agency:** _____

Date	Comments

ALL STAFF PERSONS WORKING WITH THIS INDIVIDUAL MUST FILL OUT THE INFORMATION BELOW		
Staff Name (Please Print)	Staff Signature	Initials

North Carolina Division of Mental Health/ Developmental Disabilities/ Substance Abuse Services

Consumer Name _____ **Record Number** _____ **Month/Year** _____ **Shift** _____

Specify Service: _____ **Area Program/LME** _____ **Service Provider/ Agency:** _____

Goals	Key	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	(I)															
	(A)															
	(I)															
	(A)															
	(I)															
	(A)															
Duration(when required)																
Date:																
Initials:																

GRID

Consumer Name _____ **Record Number** _____ **Month/Year** _____

Date	Comments

ALL STAFF PERSONS WORKING WITH THIS INDIVIDUAL MUST FILL OUT THE INFORMATION BELOW		
Staff Name (Please Print)	Staff Signature	Initials

Client:	Record Number	Date:

DIAGNOSIS(ES)			Type: Principal (P) Both Principal & Primary (B) Primary (R) Additional (A)
Axis	**Code**	**Type**	**Description**

Supports/ Strengths			
Date		**Date**	

Preferences			
Date		**Date**	

Problem(s)/ Need(s)			
Date		**Date**	

Client:	Record Number	Date:

Goal	Service(s) Modalities/Intervention (including frequency and duration)	Responsible Person/Position

Target Date	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal

Status Codes: R= Revised O= Ongoing A= Achieved D= Discontinued

Client:	**Record Number**	**Date:**

Staff and Client/Legally Responsible Person sign below whenever the plan is implemented/reviewed/revised.

Date	**Staff Signature**	**Date**	I have participated in the development of the Service Plan and I agree with the plan. (Client/Legally Responsible Person Signature)

Client:	**Record Number:**	**Date:**

DESIGNED BY AREA PROGRAM/ LME/PROVIDER

Service Note: Recipient, if Different from Client; Purpose of Contact; Description of Intervention/Activity; Assessment of Progress Towards Goals; Duration of Service (Periodic Day/Night Service), if not reflected above. Signature (For professional, credentials, degree or licensure. For paraprofessional, position).

CLIENT :	1) Date of Service 2) Identification of Recipient, if Different from the Client 3) Purpose of Contact 4) Description of Intervention/Activity 5) Assessment of Progress Towards Goal(s) 6) Duration of the Services **(Periodic, Day/Night Services)** 7) Professional-Signature-degree, credentials or licensure Paraprofessional-Signature-position
RECORD NUMBER :	

CLIENT :	1) Date of Service 2) Identification of Recipient, if Different from the Client 3) Purpose of Contact 4) Description of Intervention/Activity 5) Assessment of Progress Towards Goal(s) 6) Duration of the Services **(Periodic, Day/Night Services)** 7) Professional-Signature-degree, credentials or licensure Paraprofessional-Signature/position
RECORD NUMBER :	

CLIENT		**RECORD NUMBER:**	

Date	**Duration**	**Instructions:** Briefly state purpose of contact, description of intervention/activity and assessment of progress towards goal	***Signature Required**
		Purpose of Contact: **Description of Intervention/Activity:** **Assessment of Progress Towards Goal:**	
		Purpose of Contact: **Description of Intervention/Activity:** **Assessment of Progress Towards Goal:**	
		Purpose of Contact: **Description of Intervention/Activity:** **Assessment of Progress Towards Goal:**	
		Purpose of Contact: **Description of Intervention/Activity:** **Assessment of Progress Towards Goal:**	

** For professionals signature credentials, degree or licensure • For paraprofessionals signature & position*

Client Name	**Record Number:**

Date:	***Shift/Duration of Service:**
Purpose of Contact:	
Intervention/Activity (what you did:)	
Assessment of Progress Towards Goal:	
***Signature Required**	

Date:	***Shift/Duration of Service:**
Purpose of Contact:	
Intervention/Activity (what you did):	
Assessment of Progress Towards Goal:	
***Signature Required**	

Date:	***Shift/Duration of Service:**
Purpose of Contact:	
Intervention/Activity (what you did):	
Assessment of Progress Towards Goal:	
***Signature Required**	

Consumer:		**Record Number:**	

** For professionals signature credentials, degree or licensure • For paraprofessionals signature & position*

NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Client Name:				Record Number:	
Signature & Credentials, Degree/ Licensure:				Initials:	
Date	**Location**	**Type of Activity**	**Brief Description of Activity and Outcome**	**Total Time**	**Initials**
	Office	Assessing			
	Home	Arranging			
	School	Informing			
	Work/Day Prg.	Assisting			
	Community	Monitoring			
	Other (specify)	Other (specify)			
	Office	Assessing			
	Home	Arranging			
	School	Informing			
	Work/Day Prg.	Assisting			
	Community	Monitoring			
	Other (specify)	Other (specify)			
	Office	Assessing			
	Home	Arranging			
	School	Informing			
	Work/Day Prg.	Assisting			
	Community	Monitoring			
	Other (specify)	Other (specify)			
	Office	Assessing			
	Home	Arranging			
	School	Informing			
	Work/Day Prg.	Assisting			
	Community	Monitoring			
	Other (specify)	Other (specify)			
	Office	Assessing			
	Home	Arranging			
	School	Informing			
	Work/Day Prg.	Assisting			
	Community	Monitoring			
	Other (specify)	Other (specify)			
	Office	Assessing			
	Home	Arranging			
	School	Informing			
	Work/Day Prg.	Assisting			
	Community	Monitoring			
	Other (specify)	Other (specify)			
	Office	Assessing			
	Home	Arranging			
	School	Informing			
	Work/Day Prg.	Assisting			
	Community	Monitoring			
	Other (specify)	Other (specify)			
	Office	Assessing			
	Home	Arranging			
	School	Informing			
	Work/Day Prg.	Assisting			
	Community	Monitoring			
	Other (specify)	Other (specify)			

CASE MANAGEMENT ACTIVITY LOG